Provider Contracting Practices

2008 survey
of all licensed HMOs in Missouri
and PPO affiliates

DIFP
Department of Insurance, Financial Institutions & Professional Registration

Provider Contracting Practices

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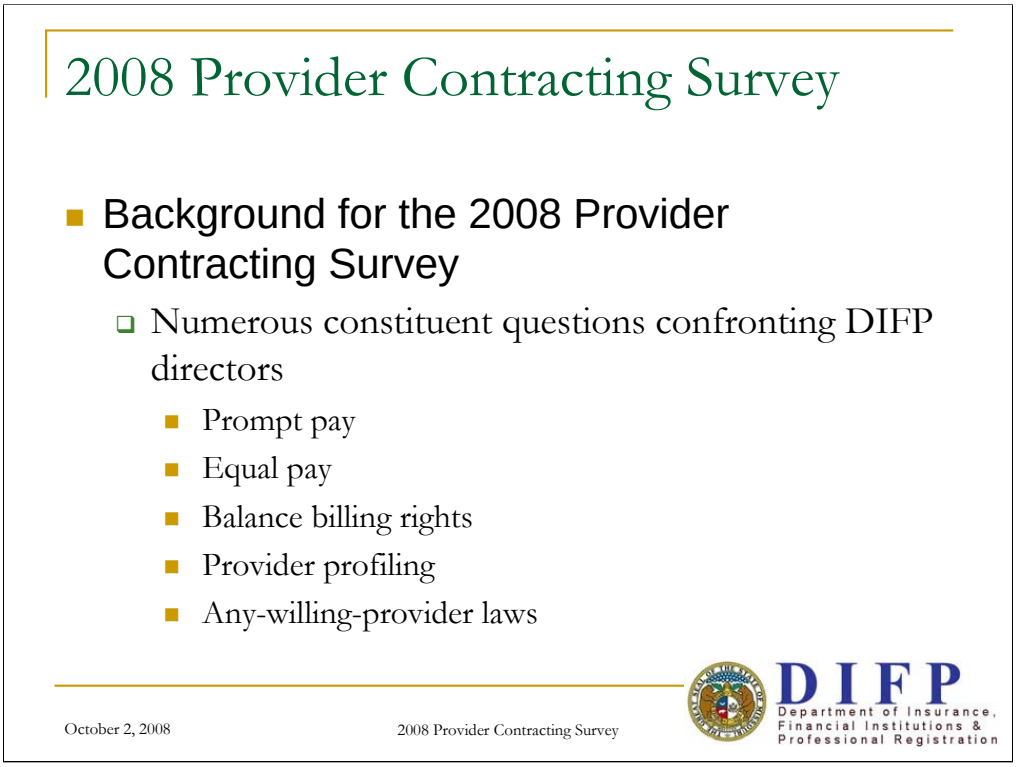
Good morning. Again, I'm Molly White with the Department of Insurance. My official titles are up there. To give you a little more background, I graduated in 1997 from Mizzou's health administration program which at that time awarded master's degrees with an emphasis in managed care. After working almost 2 years in a long term care facility with insurance, Medicare and Medicaid billing, I was hired at DIFP in 1999 as a research analyst in the relatively new Managed Care Section. The Dept. promoted me to supervisor that same year and has left me alone since then. The Managed Care Section is involved with all aspects of the regulation of HMOs, including specialized data collection. We design, implement and evaluate a wide range of data collection and policy evaluation. Today I'm going to provide you with the results of a special survey that was conducted this spring. I hope I will also have enough time at the end to go over an area of provider contracting that wasn't in our survey, but which is a simmering issue.



The first thing I want to spend some time on this morning is the survey that DIFP conducted to collect some information from managed care plans about certain provider contracting issues. During the course of 2006 and 2007, department directors were receiving an increasing number of calls from medical providers on the subject of managed care contracting issues. Upper management at DIFP was concerned about the things they heard from medical providers and also from health plans about the nature of the relationships between managed care plans and providers. Prompt pay has been a big issue, but so have rules about holding members harmless, whether or not a plan can intervene in medical decisions, any-willing-provider laws, equal payment for equivalent services, etc. One odd thing kept cropping up as a potential problem: laws in Missouri regulate the contractual relationships between HMOs and medical providers, but HMOs are no longer the dominant form of managed care plan in Missouri. There's nothing in the law that speaks specifically to the contracts between medical providers and other more loosely managed care plans – like PPOs – the way there are laws for HMOs.

2008 Provider Contracting Survey: Background

- Purpose of the survey: Do we know what we don't know?
  - We know what's in an HMO benefit plan contract and what's in a PPO benefit plan contract.
  - We know what's in HMO provider contracts and HMO provider directories
  - We don't know what's in PPO provider contracts and provider directories.

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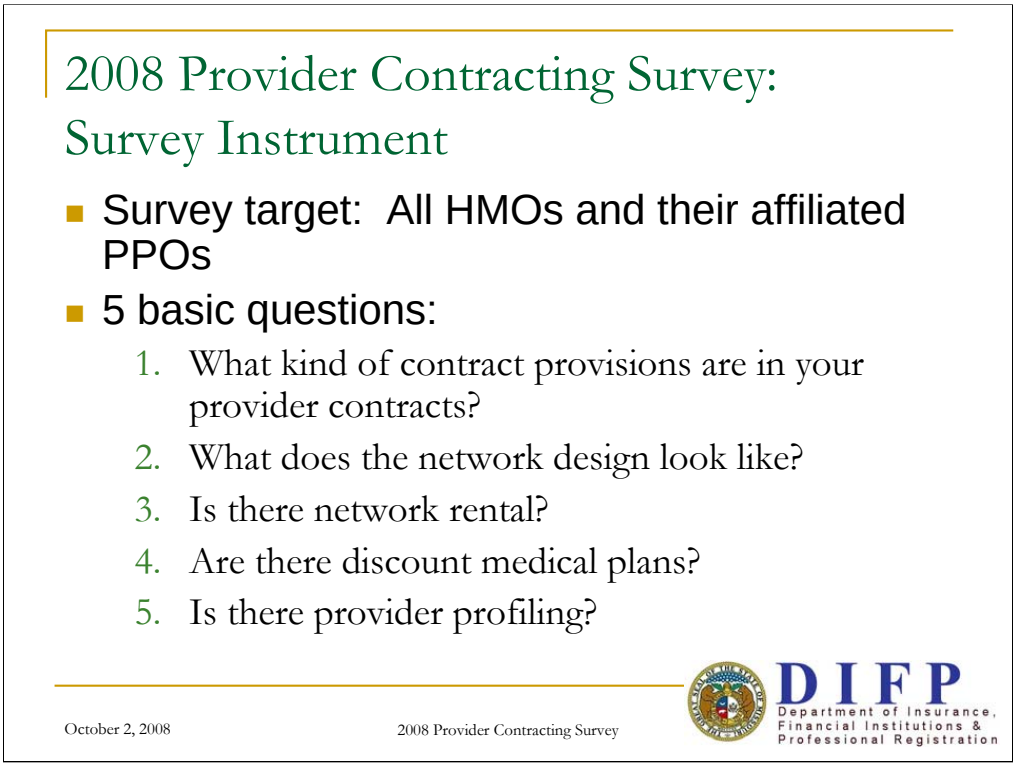
So, we had a growing pile of calls and complaints. We had lots of meetings and discussions internally. But what it really came down to is we didn't have enough information to make a good policy decision about the problems we were hearing about. We have a lot of information about HMOs – a shrinking segment of the market – and not much information at all about PPOs. While I felt pretty confident that there were a lot of similarities between the content of HMO and PPO provider contracts, I didn't have any PPO provider contracts to back me up, and we didn't have any of the other information we regularly get from HMOs. So we agreed that it would be a good start to just ask some questions.



We designed a survey targeted at both HMOs and PPOs, but we didn't have the capacity to survey all the PPOs. There are only 21 licensed HMOs in Missouri, but there are literally hundreds of companies that could be selling PPO coverage. What we know about the market is that every HMO selling commercial coverage is affiliated with a standard life and health insurance company selling PPO coverage. The affiliated PPOs cover the majority of the market. With a couple of exceptions, we felt it wasn't necessary to survey every single possible PPO as long as we surveyed most of the biggest ones.

At the time the survey went out, we had settled on 5 basic questions about the provider contracts that managed care plans use:

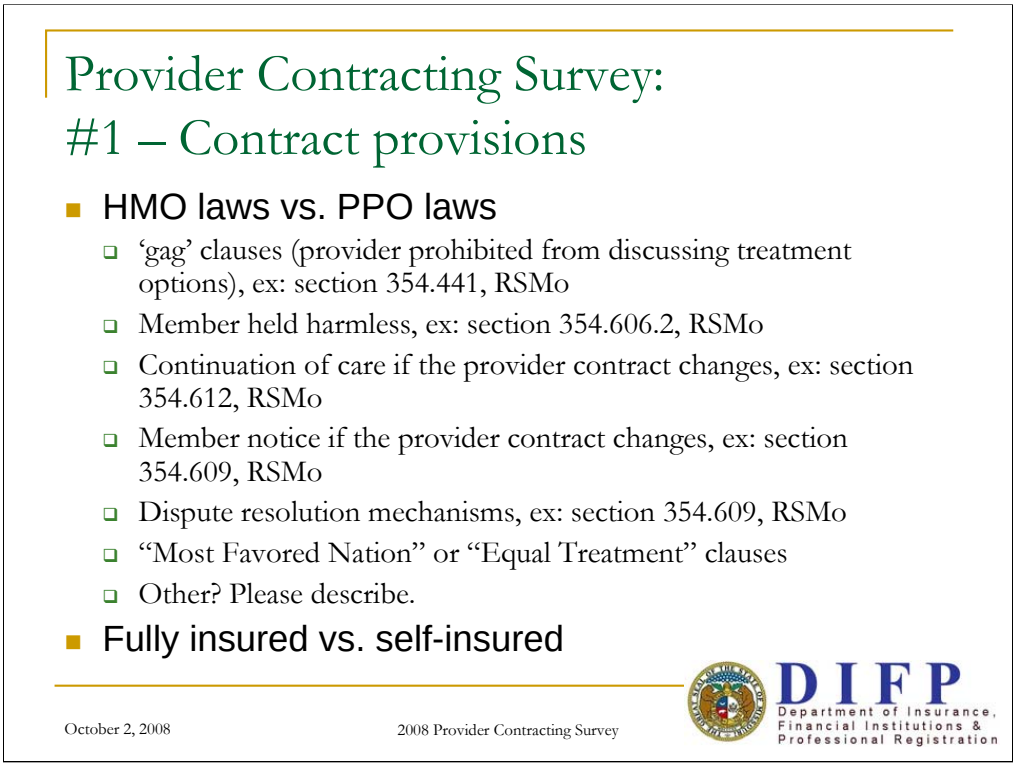
#1 - certain contract provisions that are required for HMOs

#2 - network design questions

#3 - renting networks

#4 - relationships with discount medical plans

#5 - and provider profiling



#1 – Contact provisions: Missouri has laws about what has to be in an HMO provider contract, or in a couple cases, what CANNOT be in an HMO provider contract. But there are no laws about what's in a PPO or dental plan provider contract. DIFP wanted to find out if there was any cross-over effect – were the HMO statutory requirements being picked up in other managed care plan provider contracts? And we went ahead and asked the companies to provide any relevant information about their self-insured business. Under federal law, states don't have jurisdiction over this business and we're not even supposed to ask. We were entirely dependent upon the good graces of each company to respond to this, and none of the companies had any objection to sharing this information with us.

We did not ask about pricing. There's no law in Missouri that requires provider reimbursement rates to be disclosed to us. Typically that information is sensitive and contractually protected. We assume there **are** differences in the amounts paid and the payment mechanisms between HMO and PPO plans, but we didn't feel it would be appropriate or fruitful to survey on this issue.

The results were not too surprising. Because these companies all have sister HMO and PPO companies, it seemed illogical to think that there would be one whole set of contracts for the HMO business, and a completely separate set of contracts for the PPO business. It seemed equally illogical that companies would utilize one set of contracts for fully insured business and a whole different set of provider contracts for self-insured business. By and large, these assumptions were borne out in the reports DIFP received. There were just a few differences.

Nobody uses gag clauses in their managed care contracts anymore. These are the provisions that received so much bad press in the 1990s. There is a law barring such clauses in Missouri, and in fact, most companies have "anti" gag clauses – the contract explicitly protects the provider's right to discuss any course of medical treatment with the patient.

Missouri requires HMO provider contracts to contractually prohibit the provider from billing the HMO member for anything other than the copayment or coinsurance amount. The concept of managed care pretty much breaks down without this. There's no benefit to the consumer for putting up with network restrictions if the providers in the network are just going to bill you anyway. But surprisingly, there were 3 PPO companies that reported they allow providers in their non-HMO networks to bill plan members.

Missouri law requires HMO providers to continue treating members in certain situations even after the provider has left the HMO network. Primarily this law was set up to protect women in the 3rd trimester of pregnancy, but it extends to anyone in the midst of an on-going treatment episode for a limited period of time. I personally did NOT expect this contract provision to exist anywhere the law didn't require it to exist, but in fact most companies reported they require this across the board. The same 3 companies that reported allowing providers to bill members also reported that they don't require providers to continue treating members in these medically critical situations.

Missouri law requires HMOs to notify members when a provider contract is terminated. The law doesn't say that this notice issue MUST be in the provider contract, but the provider is supposed to supply the HMO with patient information. Most HMOs have something in their provider contracts about this, although 4 HMOs said they didn't address it thru the provider contract. Different companies than the other 2 questions. In the PPO contracts, there is a contract provision most of the time, but not always.

All HMO contracts contain some kind of dispute resolution mechanism – the law doesn't dictate what kind, just that there has to be one. One company reported that their provider contracts for self-insured HMO business don't address dispute resolution. Not too surprisingly, all PPO provider contracts have a dispute resolution, even in the self-insured market. Some companies reported for other lines of business, such as dental plans, and evidently some of those contracts don't address dispute resolution.

Missouri managed care laws don't address the issue of "most favored" pricing. It's not explicitly prohibited and in fact a few companies are using these clauses. The reporting indicated that such clauses were used only in a very few cases. DIFP is in the midst of a joint evaluation with the Attorney General's office about the permissibility of these clauses. Because it's an issue of market competition, each such clause has to be evaluated on its own merits and in its own context. Absent a specific law on the subject, it's just not possible to say that all such clauses are permissible or that they are all prohibited. DIFP's primary concern in asking this question was just to be certain that the HMO contracts that require prior approval had been filed with the Dept. For companies that report using these contract provisions, there appears to be no difference in treatment between fully-insured and self-insured markets when it comes to the provider contract.

We used an "other" line item in the survey, but most companies left it blank. The companies that responded indicated there wasn't any other area of difference between their HMO and PPO contracts.

Provider Contracting Survey: #1 – Contract Provisions

Contract Provisions	HMO fully insured present	HMO fully insured absent	HMO self insured present	HMO self insured absent	PPO fully insured present	PPO fully insured absent	PPO self insured present	PPO self insured absent	Other (please describe) present	Other (please describe) absent
Gag Clause	0	21	0	13	0	12	0	12	0	7
Hold Harmless	21	0	12	1	11	1	11	1	4	3
Continue Care	20	1	11	2	10	3	10	3	3	4
Member notice	15	6	9	4	9	4	9	3	3	5
Disputes	20	1	11	2	12	0	12	0	3	4
MFN	5	14	4	8	3	9	3	9	3	5
Other	0	5	0	3	0	3	0	3	0	3

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Here's just a summary of the data reported in response to this first question. You can see we didn't get an answer to every part of the question from every company, but we did feel the responses were sufficient to give us a broader perspective than we had before.

Provider Contracting Survey: #2 – Network design question

- 3 part question:
  - Are there different layers in the network?
  - What is the financial impact on members?
  - What's in the provider directories?
- Results:
  - 2 companies reported layered networks
  - Layers apply across the board
  - Member notification varies

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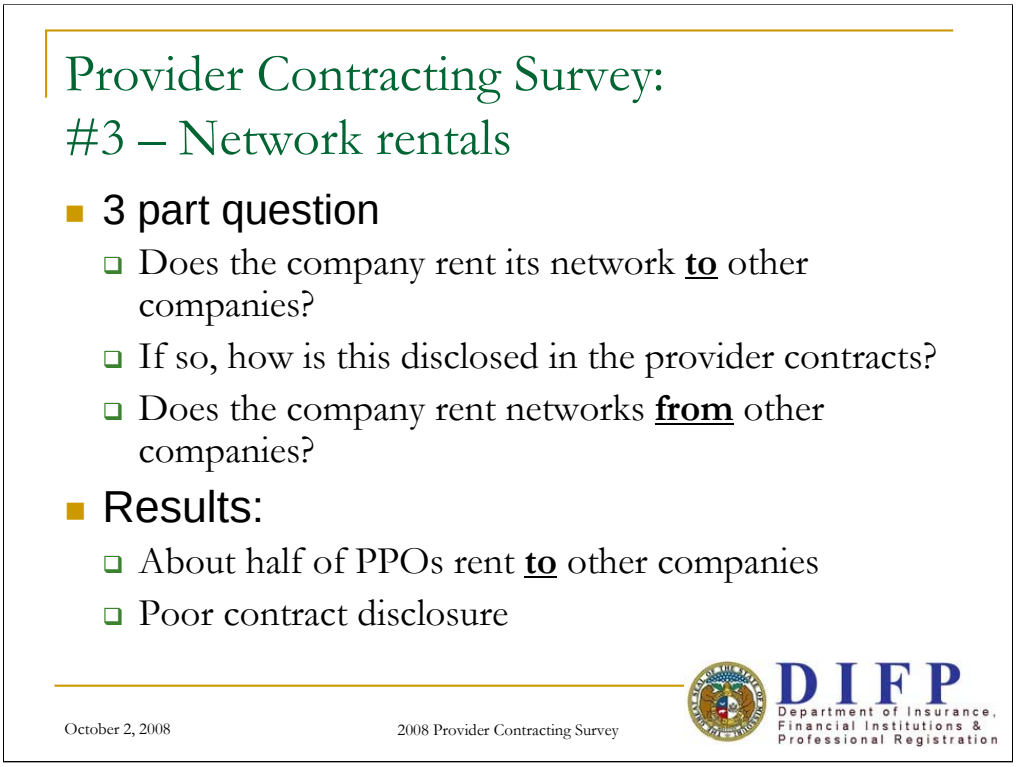
#2 – Network design: Most folks understand managed care as a plan where if you go in-network you have benefits, and if you go out-of-network, you don't have benefits, or your benefits aren't as good. But, nothing more complicated than in vs. out. As it happens, there are situations where it IS more complicated than in vs. out. There's one company that we know of in Missouri that's been operating a 3-layer network for a long time. In Missouri and nationally, there's been rumblings of tying provider profiling activities to different layers of a provider network. When I say "layers" I mean that there's more than 2 levels of benefits. There's at least 3 levels, and certainly the possibility for more levels. In very simple terms, there's a top layer of providers that are favored for some reason. The company finds it worthwhile to impose very low member cost-sharing at the top level. Not going to get into how a company decides which providers are in the top level because that's pretty contentious at the moment. But then there's another layer of providers that are still "in-network" but they aren't as favored. Member cost sharing is higher, but not as high as if the member goes to a provider with no contractual relationship to the plan at all.

Missouri law currently doesn't address the issue of layers very clearly. It's just not something people generally have much experience with yet. So DIFP just wanted to know how much of it is happening. We didn't think there was very much, and in fact, nothing was reported that we didn't already know about. The only skin that DIFP really has in the game is how good a job the companies are doing of helping plan members understand the potential financial impact. We have one company that doesn't tell plan members much about the middle layer of providers – and with good reason from that company's point of view – I have no intention of implying that the company is doing something wrong here. And we have the other company that is making a big deal of the difference between the top layer and the middle layer for the member, again, without trying to pass any kind of judgment about the right way to do it. That's just what's out there now. Since the survey was carried out, DIFP is aware of one additional company planning on implementing layered networks, and that company also is doing it with the intent to make a big deal of the different layers to the member.

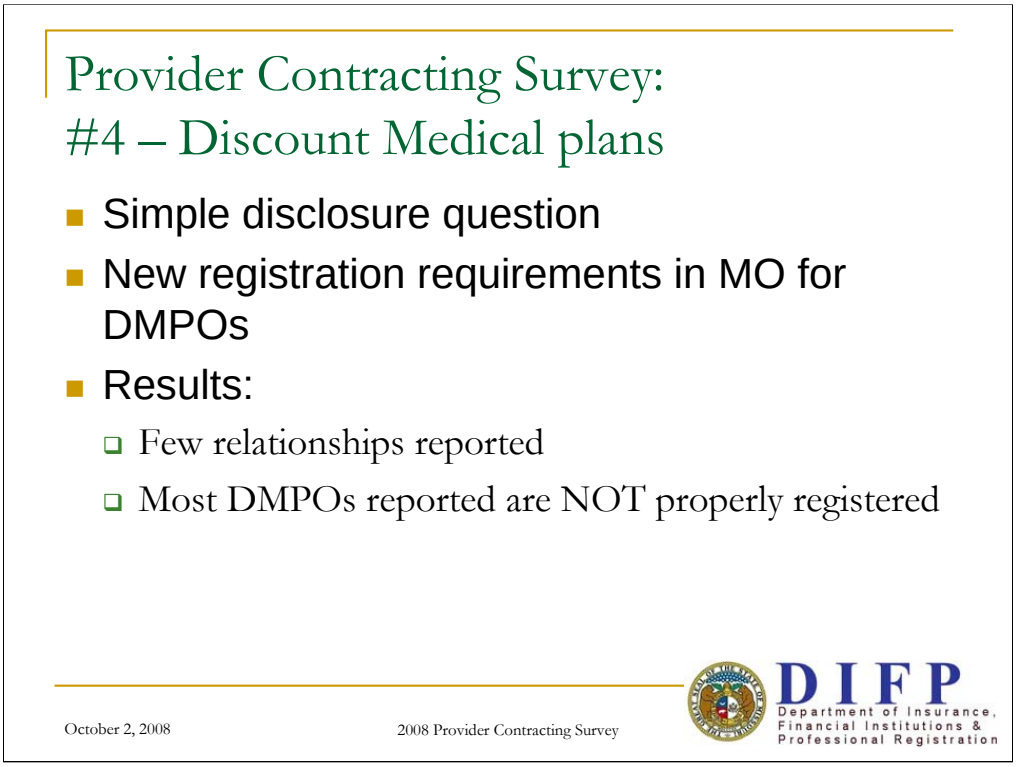
So the take-home message for us at the Dept. is certainly that this could become a more common arrangement in the future. We may need to make some policy decisions about these arrangements because the laws don't exist right now, and maybe that's OK too. This is a big area of learning and new experience for us as regulators.



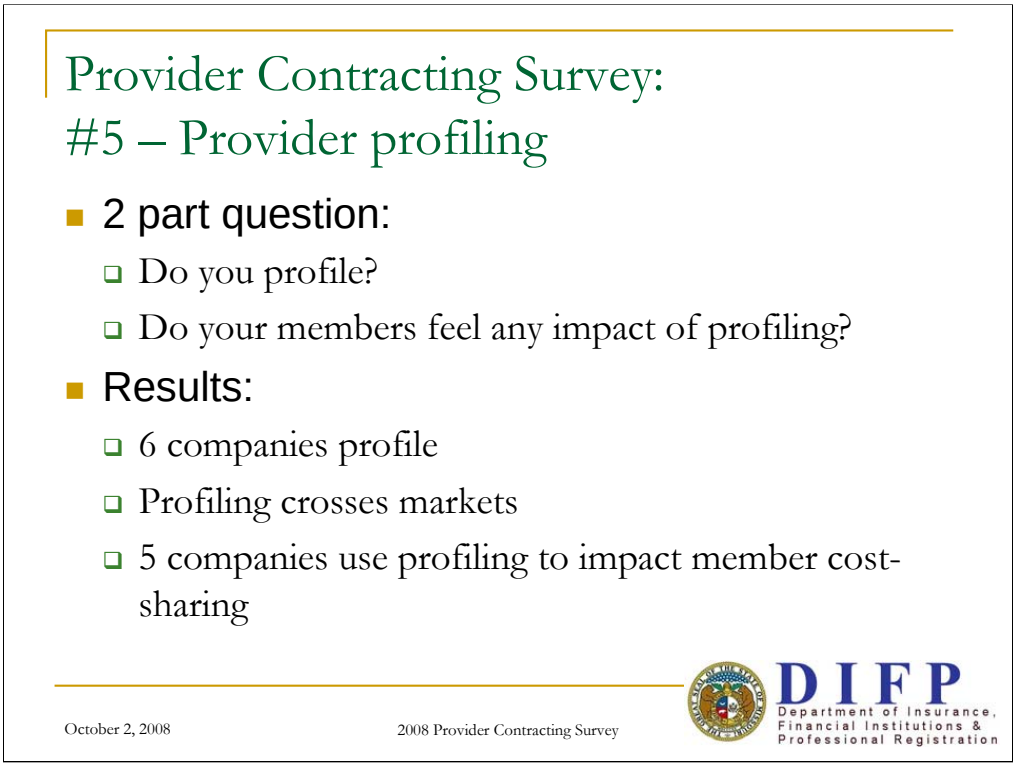
#3 – Network rentals: This question was intended to cover both subcontracting and also silent PPOs. Does anyone need me to explain what I mean by "silent PPOs"? [[These are arrangements where a company sets up a provider network and negotiates prices with providers, and then turns around and charges another company a fee to use the same network at the same prices. Plan members from the 2nd company can go the 1st company's network and enjoy the same price discounts. Providers often feel that these arrangements wind up extending discounted prices to a far greater number of patients than the provider realized or intended, reducing the provider's expected level of income.]] Although few of the HMOs operating in MO are renting their networks **to** other companies, their non-HMO affiliates are more active in this area.

Based on the complaints DIFP has heard, it was not surprising that we didn't see clear evidence of any company meeting the kinds of disclosure guidelines that the AMA and similar organizations are wanting.

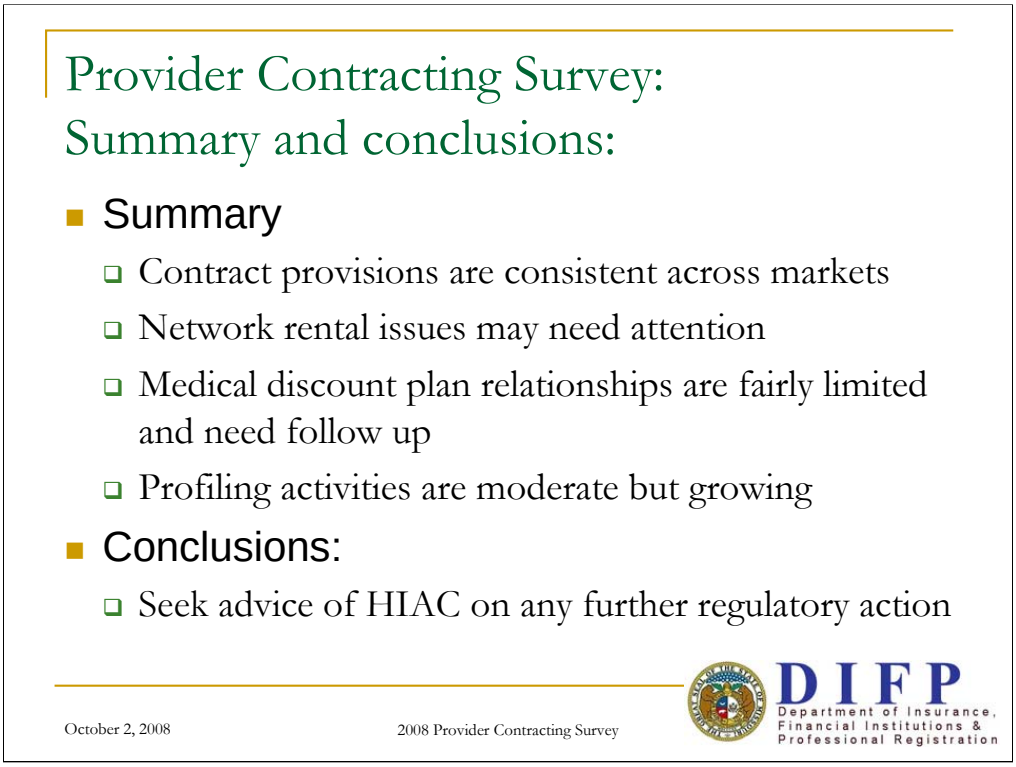
Over half the HMOs rent networks **from** other companies, although this was actually more associated with using a carve-out vendor for a whole category of service, such as dental benefits. So instead of asking if companies **rent** networks from other companies, it might have been more fruitful to ask directly about the use of re-pricing arrangements. At any rate, we're able to confirm that companies in Missouri are engaged in rental activity that would probably be considered "silent PPOs". This is a real candidate issue for this committee. It's an issue that could be addressed non-legislatively by just working together. There might need to be legislation, but I'm willing to bet that a lot of ground could be covered just by getting the right people together to talk about this.



#4 – Discount Medical Plans: This was just something we threw in sort of at the last minute as new laws in Missouri requiring registration were going into effect. The intent was just to round up any discount medical plans that may not have known the law changed in Missouri, and engage in any necessary outreach. Not many of the companies we surveyed have relationships with discount medical plans at this time. Of the few discount medical plans reported, most of them were NOT registered with DIFP. The Dept. is considering appropriate follow-up activity.



#5 – Provider Profiling: Missouri law expressly allows provider profiling and addresses the need to assure that profiles are based on quality of care. But profiling activities are not required to be filed or approved by DIFP unless the profile is tied to a provider incentive arrangement. DIFP has a handful of such incentive arrangements. But the growing trend is to use the profile data in a way that either discloses provider variation to members and allows members to decide whether or not to use the information, or the profile data is tied to layers in the network. Since Missouri law is very minimal on the topic of provider profiling, the only way DIFP is going to have any information about it is likely going to be thru case-by-case complaint investigations or thru special information requests such as this survey. DIFP's primary goal in asking this question was just to get a more comprehensive view of the scope of this activity than the view we get from investigating complaints. DIFP has no plans to take regulatory action on this topic or to immediately repeat this kind of information gathering. This would be one where we would certainly be open to the suggestions of the committee for any further activity on our part.



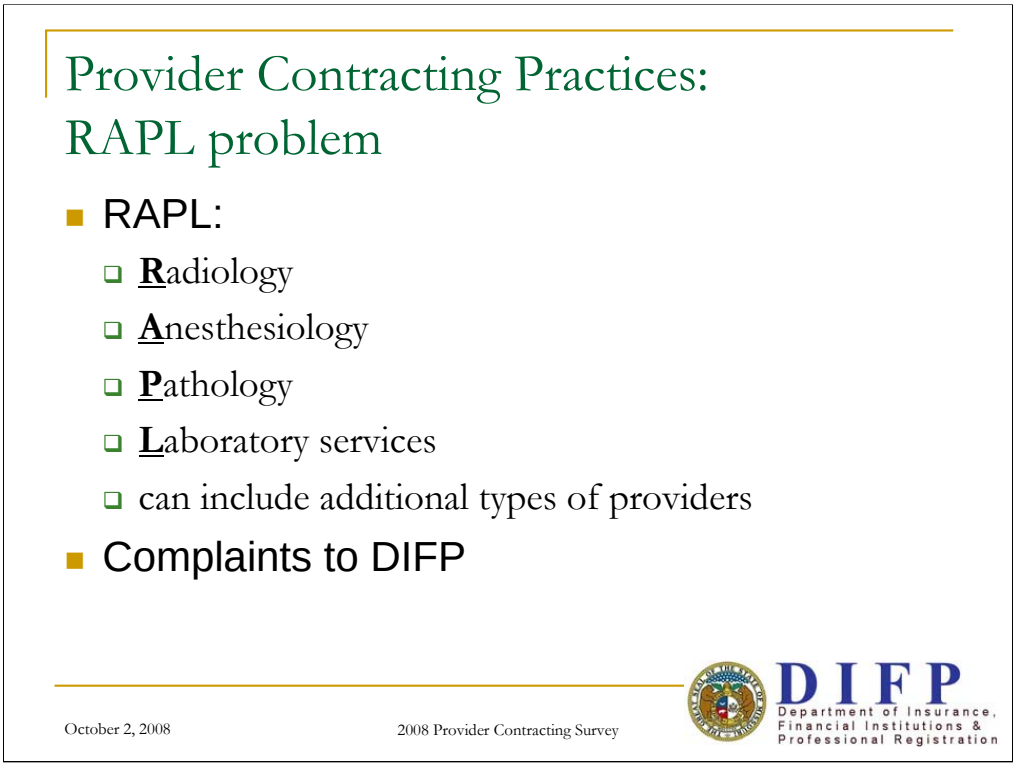
So to quickly summarize: some of the hot-button contracting provisions that are regulated for HMOs are actually also carried over to other markets.

Network rental issues are more common outside the HMO markets, and may need some kind of attention to address provider concerns about these arrangements.

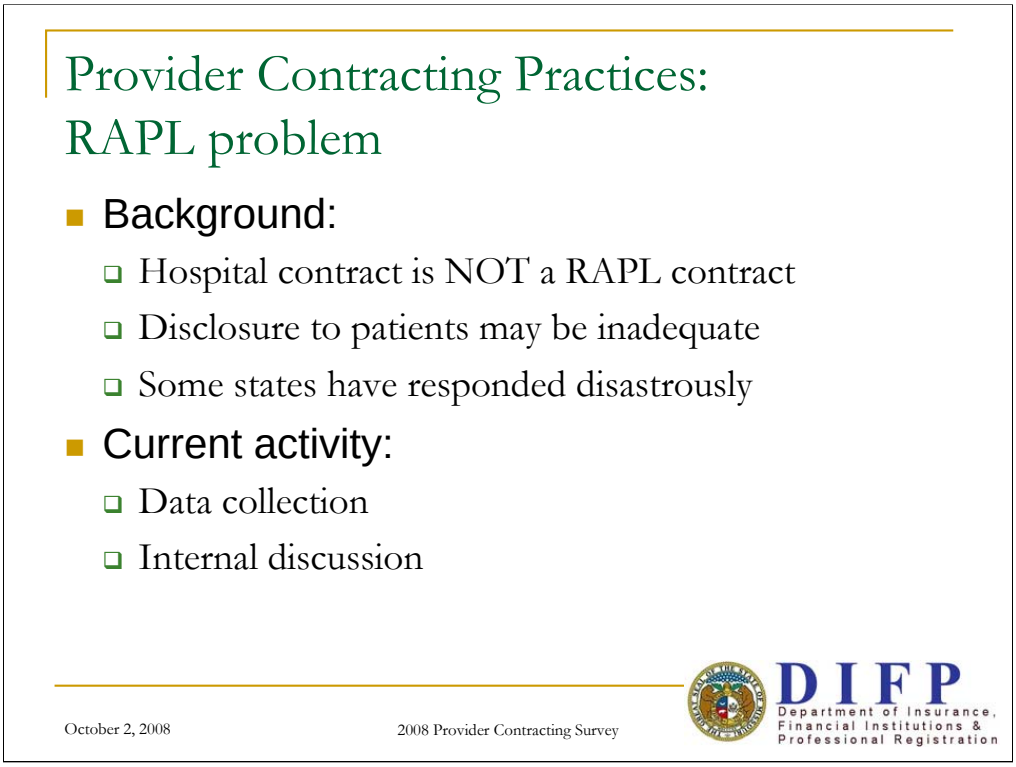
DIFP has some follow-up work to do with regard to the new Discount Medical Plan registration requirements.

Profiling activities are gaining ground and it may be appropriate to think about some collaborative efforts here.

Certainly the most useful conclusion to draw is to find out from the people on this committee what they think is needed in these areas.



The last item I want to touch on briefly is the issue of hospital based providers. At DIFP we have adopted at term, "RAPL" as a catch-all for this issue. RAPL is an acronym and you can see what it stands for. There are other acronyms out there, but this is what you'll hear us use. The issue is the increasing number of complaints and inquiries DIFP has received regarding members who are billed by these providers. Data tracking is a little sketchy but we know this is a growing area of concern. What has happened is a slight shift in the market related to contract difficulties that managed care plans have actually had with RAPLs for a long time.

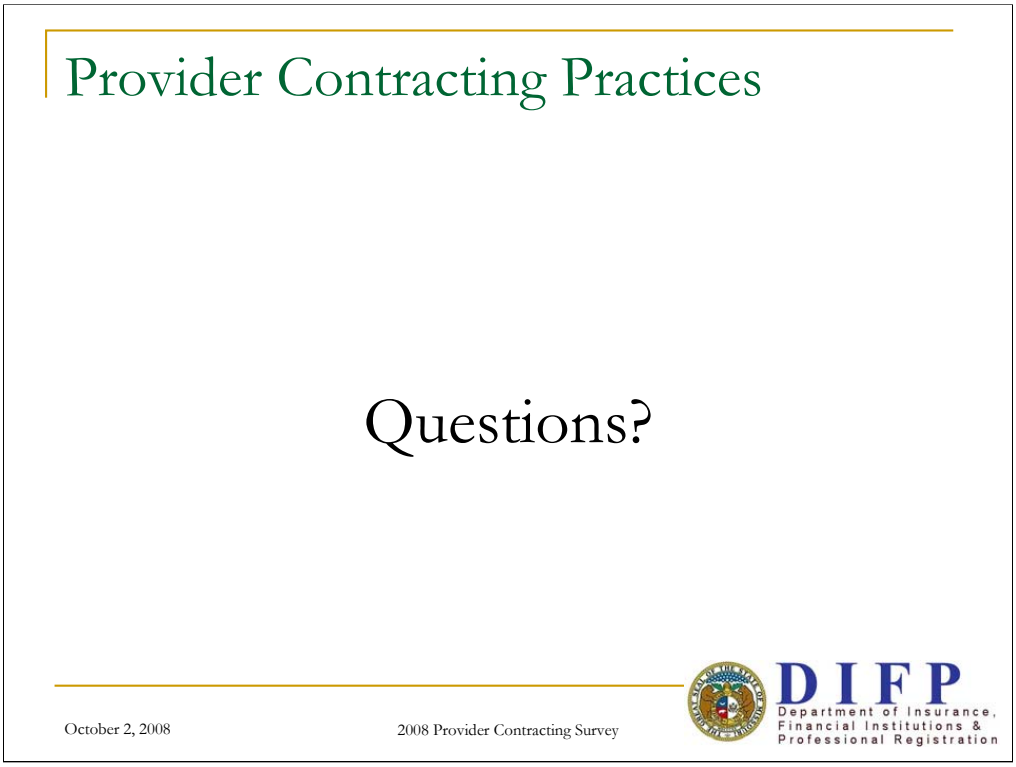


A hospital is a unique form of business. At most hospitals, the building itself represents one independent corporate entity, but the service providers working inside the hospital, such as the radiology department, the ER, the lab, the anesthesiology group, etc., these are typically are independent corporate entities. Even the medical staff is not the same corporate entity as the hospital. So when a managed care plan has a contractual relationship with a hospital, that's not a relationship with the medical professionals at the hospital. 20 years ago, the hospital contracts were more inclusive, but one of the reactions to managed care was that all these professional groups wanted their own contract, separate from the hospital's contract. At this point in time, the hospital contracts DIFP sees tend to exclude the RAPLs. Since the contracts are separate, it often happens that the managed care plan can get a contract with the hospital, but can't get a contract with all the RAPLs at the hospital. This situation has been around for a long time. The problem is that it appears that managed care plans are changing so that the patient or plan member can be exposed more often to the financial consequences of this break-down in contractual relationships. The nature of the complaints that DIFP gets is that the member thought they did everything right – they went to a par hospital, they got services prior-authorized, the surgeon is in-network, they paid their hospital copay. Then the member is surprised to get a bill from the anesthesiologist associated with that hospital stay. The member doesn't understand why the hospital copay didn't cover everything.

To varying degrees, some plans are trying to warn members about this, and some plans are simply continuing to shield members from the financial consequences by either paying billed charges, or by negotiating on a case-by-case basis with the providers, without signing a permanent contract. A few plans are really making it as clear as possible in their plan documents and their provider directories that this is a potential problem and the plans are explaining which hospitals are affected. But a lot of other plans are barely mentioning this issue. The benefit contract says just

enough to avoid regulatory action, but not enough to truly inform members. Sometimes the disclosure is very confusing because the issue is very confusing. Missouri is certainly not the only state confronted with this problem. It's a nationwide phenomenon. Some states have taken some action to try to correct the problem. But at least one state, Colorado, adopted a solution that was worse than the original problem. A natural consumer advocacy response to this problem is to just require that managed care plans pay the RAPLs and hold the member harmless. Colorado enacted legislation along these lines. They required all plans to pay the RAPLs regardless of the RAPLs' participation status. A natural response from the providers in Colorado was to immediately terminate all managed care contracts and cease any managed care discounting. Prices for medical services within the hospital setting soared and the Colorado Dept. of Insurance was sued. I'm not sure the current status of that situation or if any other states took such disastrous action. But some other states have looked at other possible approaches, such as stiffer disclosure requirements. DIFP will be participating in a conference call next week with the New York Dept. of Insurance on this subject. But what DIFP has done in the mean time is to try again to collect data that can give us a more complete understanding of the problem.

Every year since 2005, the HMOs have been asked to name the hospitals within their network where there are non-participating RAPLs that could be providing services to members, and to explain what is the financial impact the member experiences and how the member is informed. At this point, all the HMOs are basically shielding their members from the problem. In fact they're being pretty aggressive in their efforts to negotiate with the RAPLs on a case-by-case basis. A couple HMOs stand out in their efforts to inform members of the potential problem. DIFP has not collected comparable information from PPO plans, and it appears that the largest volume of complaints is associated with PPO or POS plans, where there is an out-of-network benefit that kicks in, even tho the member went to an in-network hospital. Since the market has shifted almost completely away from HMO plans in favor of PPO and POS plans, DIFP is dealing with more people impacted with this type of problem. This is an area where I think there's a lot of room for discussion and advice from Committee members.



That's it as far as the information I wanted to present to you. And I hope you have some questions for me.